

**SCREENING FOR MENTAL ILLNESS, INTELLECTUAL/DEVELOPMENTAL DISABILITY,  
OR RELATED CONDITIONS**

For Placement in the Alzheimer's Assisted Living Waiver

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medicaid No. \_\_\_\_\_

1. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF ALZHEIMER'S OR ALZHEIMER'S RELATED DEMENTIA?    Yes    No
2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)?    Yes    No  
(Check "Yes" only if answers a, b, and c below are "Yes").
  - a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)?  
Yes    No
  - b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change?    Yes  
No
  - c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder?    Yes    No
3. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF INTERLLECTUAL/DEVELOPMENTAL DISABILITY (IDD) WHICH WAS MANIFESTED BEFORE AGE 18?  
Yes    No
4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION?    Yes    No  
(Check "Yes" only if each item below is Checked "Yes").
  - a. Is the condition attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina befida), other than MI, found to be closely related to MR/ID because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR/ID persons and requires treatment of services similar to those for these persons?    Yes    No
  - b. Has the condition manifested before age 22?    Yes    No
  - c. Is the condition likely to continue indefinitely?    Yes    No
  - d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living?    Yes (If yes, circle applicable areas)    No

**Print Name/Street Address/Phone Number**

Physician or Licensed Clinical Psychologist

\_\_\_\_\_

**Signature/Date**

Physician or Licensed Clinical Psychologist

\_\_\_\_\_

SCREENING FOR MENTAL ILLNESS, INTELLECTUAL/DEVELOPMENTAL DISABILITY, OR RELATED CONDITIONS  
For Placement in the Alzheimer's Assisted Living Waiver Program  
INSTRUCTIONS FOR COMPLETION

IDENTIFYING DATA

**NAME:** Enter the Individual's Full Name

**DATE OF BIRTH:** MM/DD/YYYY

**MEDICAID NUMBER:** Enter the 12-digit number

- 1 Indicate whether the individual has a diagnosis of Alzheimer's or Alzheimer's related dementia. If "yes" is checked, complete the screening. If the individual does NOT have one of these diagnoses, do not complete screening. If criteria are not met, the individual cannot be admitted to the Alzheimer's Assisted Living Waiver.
- 2 **Determination of Serious Mental Illness (MI):** Check "yes" (that the individual has a current diagnosis of serious MI) only if 2 a, b, and c are checked "yes". Indicate the diagnosis if "yes" is checked.
  - a. Check "yes" if the individual has a major mental disorder diagnosable under DSM-III-R (e. g. schizophrenia (including disorganized catatonic, and paranoid types), mood (including bipolar disorder, mixed manic, depressed, seasonal, NOS). Major depression (single episode/recurrent, chronic, melancholic or seasonal), depressive disorder NOS, cyclothymia, dysthymia (primary/secondary or early/late onset). Paranoid (including delusional, erotomanic, grandiose, jealous, persecutory, somatic, unspecified, or induced psychotic disorder), panic or other severe anxiety disorder (including panic disorder with agoraphobia. agoraphobia with or without history of panic disorder, social phobia general w ed anxiety disorder, obsessive compulsive disorder, past-traumatic stress disorder), somatoform disorder (includes somatization disorder. conversion disorder somatoform pain disorder, hypochondriasis. body dysmorphic disorder, undifferentiated somatorm disorder, somatoform disorder NOS). Personality disorder (includes paranoid. schizoid. sehizotypal. histrionic, narcissistic, antisocial, borderline. avoidant, dependent. obsessive compulsive, passive aggressive, and NOS), other psychotic disorder (includes schizophreniform disorder. schizoaffective disorder (bipolar/depressive), brief reactive psychosis, atypical, NOS) or other mental disorder that may lead to a chronic disability).
  - b. Check "yes" if the individual has a mental disorder that has resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning concentration, persistence, and pact, arid adaptation to change.
  - c. Check "yes" if the individual's treatment history indicates that he or she has experienced (1) psychiatric treatment more intense than outpatient care more than once in the past 2 years or (2) within the last 2 years, an episode of significant disruption to the normal living situation due to the mental disorder.
3. **Determination of Intellectual/Developmental Disability (IDD):** Check "yes" if the individual has a level of retardation or disability (**mild, moderate, severe, or profound**) that was manifested before **age 18**.
4. **Determination of Related Conditions:** Check 'yes' only if each item in 4 a-d below is checked.
  - a. Check 'yes' if the condition is attributable to any other condition (e g, cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI. found to be closely related to IDD because this **condition** may result in impairment of general intellectual functioning or adaptive behavior similar to that of **MR/ID** persons and requires treatment or services similar to those for these persons.
  - b. Check "yes" if the condition has manifested before **age 22**.
  - c. Cheek "yes" if the condition is likely to continue indefinitely.
  - d. Check "yes" ii the condition has resulted in substantial limitations in 3 or more of the following areas of major life activity self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living Circle the applicable areas.

**NOTE: WHEN A SCREENING HAS NOT BEEN PERFORMED PRIOR TO AN INDIVIDUAL'S ADMISSION TO A NF IN A TIMELY MANNER, FEDERAL FINANCIAL PARTICIPATION (FFP) IS AVAILABLE ONLY FOR SERVICES FURNISHED AFTER THE SCREENING', HAS BEEN PERFORMED,**

**Physician Information or Licensed Clinical Psychologist:**

**Physician or Licensed Clinical Psychologist Signature:**

**Printed Physician or Licensed Clinical Psychologist Name:**

**Physician Signature Date:**

**Telephone Number:**

**Street Address:**

First Name, Middle Initial, and Last Name

Print the full name of the physician signing the form

Date screening was completed

Telephone number, including area code

Complete Street address; include city/state/zip code